For KASPER Staff Only

REQUEST FOR KASPER REPORT

Please print or type information in all fields.

Patient Name _____
First Last

Address _____

City _____, ____ Zip _____

ID _____
ID Type (check one): SSN ❑ Driver's License ❑

DOB _____ / _____ / _____
mm dd yyyy

Is/was the patient known by other names? Other Names* ❑
Does/did the patient have other addresses? Other Addresses** ❑

Date Range for Report

From _____ To _____
mm / dd / yyyy mm / dd / yyyy

DEA# _____ _____

Requestor Name _____
Print Name of Prescriber or Pharmacist

Fax Back _____

❑ * Other Names (check Other Names box, above)

1. _____
First Last
2. _____
First Last
3. _____
First Last

❑ **Other Addresses (check Other Addresses box, above)

1. _____
2. _____
3. _____

Requestor Details

_____
Prescriber or Pharmacy Address

_____
Prescriber or Pharmacy City, State, Zip

_____
Facility or Pharmacy Contact Name

_____
Prescriber or Pharmacy Telephone

I certify that the information will be used for the purpose of providing medical or pharmaceutical treatment to a current or prospective patient.

_____
Requestor Signature (Prescriber or Pharmacist)

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Limit 15 Pages per Fax

Cabinet for Health and Family Services
Office of Inspector General/Division of Fraud, Waste & Abuse
Drug Enforcement and Professional Practices Branch
275 East Main Street
Frankfort, KY 40621 Phone 502-564-7985 Fax 502-564-2203

Kentucky UNBRIDLED SPIRIT™

Kentucky All Schedule Prescription Electronic Reporting (KASPER)